STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005040	A. BUILDING: _____ B. WING _____	C 10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICE	1850 STATE ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Complaint Number: IN00157061 Unsubstantiated; lack of sufficient evidence Date of survey: 10/22/14 Facility number: 005040 Surveyor: Jennifer Hembree RN Public Health Nurse Surveyor Floyd Memorial Hospital is in compliance with 410 IAC 15-1.6-8, Surgical services, Hospital Licensure Rules. QA: claughlin 10/24/14	S 000		